

DEPARTMENT OF HEALTH & HUMAN SERVICES
Survey and Certification Group
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Survey and Certification Group



April 15, 2008
Linda Krulish, PT, MHS, COS-C
President
OASIS Certificate and Competency Board, Inc
223 East Main Street
New Iberia, LA. 70560

Dear Ms. Krulish:

Thank you for your letter of April 3, 2008 in which you requested review of a number of questions and scenarios related to data collection and accurate scoring of Outcome and Assessment Information Set (OASIS) items. The attached questions and answers have been reviewed by CMS staff and consensus on the responses has been achieved. As deemed valuable for providers, OASIS Education Coordinators and others, we will consider incorporating these questions and answers into future updates to the CMS Q&As posted at <https://www.qtso.com/hhdownload.html>, and/or in future revisions to the OASIS User Manual, Chapter 8, Item-by-item Tips.

In the meantime, you are free to distribute these responses through educational offerings sponsored by the OASIS Certificate and Competency Board, Inc. (OCCB) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

Sincerely,
Patricia M. Sevast, BSN, RN
Nurse Consultant
Survey and Certification Group
Centers for Medicare & Medicaid Services

Cc: Debora A Terkay, RN, MS
Office of Clinical Standards and Quality



CMS OCCB Q&As – April 2008

CATEGORY 2 – Comprehensive Assessment

60 day payment episode

Question 1: If an agency sends an RN out on Sunday to provide a non-billable initial assessment visit for a PT only case and the PT establishes the Start of Care on Monday by providing a billable service, is the 60-day payment episode (485 “From” Date) Sunday or Monday?

Answer 1: The Medicare Benefit Policy Manual explains: “**10.4 - Counting 60-Day Episodes** (Rev. 1, 10-01-03) **HH-201.4 A. Initial Episodes** The “From” date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The “To” date is up to and including the last day of the episode which is not the first day of the subsequent episode. The “To” date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.”

The “To” date (the 60th day of the payment episode) marks the end of the payment episode for the purposes of determining if a subsequent episode is adjacent or not for M0110 Episode Timing.

The Start of Care is established when a service is provided that is considered reimbursable by the payer. If an agency sends a clinician to the patient’s home to provide a non-billable service, it does not establish the Start of Care. The Medicare PPS 60 day payment episode (485 From Date) begins on the date the first billable service is provided. In your scenario, the episode begins on Monday when the PT provides a billable service.

This guidance can be found in the Medicare Benefit Policy Manual
<http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>

CATEGORY 3 – Follow-up Assessments

RFA 5

Question 2: Since the SCIC assessment is no longer available, what should we do when additional services must be added after the SOC has been submitted and the HHRG established? If a nursing-only patient experiences a fall several weeks into the episode resulting in the initiation of PT, what OASIS assessment should we complete to get additional payment?

Answer 2: The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient’s plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

Under PPS 2008, if the patient experiences a major improvement or decline in status after the SOC assessment time frame, assessments should continue to be completed per the CoPs and

agency policy, and appropriate care plan changes made per physician orders. In some cases, (e.g., a status decline resulting in an increase in nursing visits for treatment of a new wound) no additional payment would be received, as the Significant Change in Condition (SCIC) payment adjustment has been eliminated with PPS 2008. In cases where the major decline or improvement in the patient's status results in more therapy visits being provided (compared with the number initially reported in M0826 at the SOC), upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M0826.

No specific action related to OASIS data collection or correction is necessary or expected in order for the agency to receive payment for the actual number of qualified therapy visits provided.

CATEGORY 4b – OASIS Data Items

M0080 - Admission OASIS

Question 3: Can a speech therapist do a non-bill admission for a physical therapy only patient? I have an ST that told me that she has done them for another home care agency and wants to do them for us. I have only allowed an RN or PT to do PT only admits.

Answer 3: The Comprehensive Assessment of Patients Condition of Participation (484.55) states in Standard (a) (2) "When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional." Some agencies' policies make this practice more restrictive by limiting some of the allowed disciplines (i.e., PT, OT, and/or SLP) from completing the initial assessment visit and/or comprehensive assessment, and require an RN to complete these tasks, even in therapy only cases where the therapy discipline establishes program eligibility for the payer. While not necessary, it is acceptable for agencies to implement this type of more stringent/restrictive practice. Even though there are no orders for nursing in a therapy only case, the RN may complete the initial assessment visit and the comprehensive assessment, as nursing, as a discipline, establishes program eligibility for most, if not all payers.

In a case where PT is the only ordered service, and assuming physical therapy services establish program eligibility for the payer, the PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit, and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).

It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be reimbursable visits, therefore would not establish the start of care date for the home care episode.

M0090

Question 4: Should the M0090 date be changed when a correction is made after a clinician has completed the assessment but before the assessment is locked? For example, the nurse completes the assessment with a M0826 response of 3 visits on February 1st and records that date at M0090. On Feb 2nd the nurse learns that the therapist assessed the patient and received physician orders for 10 therapy visits. Should the M0090 date be changed to February 2nd to reflect the date that M0826 is corrected?

Answer 4: If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a M0 item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.

M0110

Question 5: I am uncertain how to answer M0110 in the following situations, please clarify:

- a. Payer is Medicare PPS?
- b. Payer is a Medicare HMO that requires a HHRG/HIPPS code?
- c. Payer is a Medicare HMO that does not require a HHRG/HIPPS code?
- d. Payer changes from Medicare PPS to Medicare HMO?
- e. Primary payer for skilled home care services does not require a HIPPS code for billing, but Medicare is the secondary payer?
- f. M0110 at the Resumption of Care?

Answer 5: Utilize the following grid to determine the correct response for M0110 based upon payer and need for an HHRG/HIPPS code.

Payer	1-Early	2-Later	UK	NA
Medicare PPS	X If 1st or 2nd adjacent PPS episode	X If 3rd or > adjacent PPS episode	X If you don't know, and/or will not be making efforts to find out	X If ROC not in last 5 days of episode
Non-Medicare PPS payer who requires a HHRG			X Always	
Non-Medicare PPS payer who does not require a HHRG				X Always

- a. For a Medicare PPS payer, mark 1-Early if 1st or 2nd adjacent episode, mark 2-Later if 3rd or > adjacent episode, mark UK if you don't know and/or will not be making efforts to find out.
- b. For a Medicare HMO payer that requires an HHRG/HIPPS, mark UK.
- c. For a Medicare HMO payer that does not require an HHRG/HIPPS, mark NA.
- d. For a Medicare HMO payer (after pay source change from Medicare PPS), mark UK if the Medicare HMO requires a HHRG/HIPPS, and NA if they do not. Since adjacent episodes should only include those episodes paid by Medicare Fee-for-service (PPS), the

new Medicare HMO paid episode will not count when determining episode placement, so it is neither the first or second adjacent episode (early), or the 3rd or higher (later).

- e. There is CMS guidance (see CMS OASIS Q&A Category 4b, Q24) that suggests “When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer.” **If Medicare PPS is the secondary payer, respond to M0110 the same as if Medicare PPS was the primary payer; mark 1-Early if 1st or 2nd adjacent episode, mark 2-Later if 3rd or > adjacent episode, mark UK if you don’t know and/or will not be making efforts to find out.**
- f. **For M0110 at ROC:** M0110 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4), data from M0110 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0110 is also collected at the ROC (RFA 3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not need for payment, response NA - Not Applicable: No Medicare case mix group to be defined by this assessment could be reported on M0110.

Alternatively, upon ROC, providers may choose to report the same M0110 response that was reported at the SOC (or Recert) assessment that began the current episode, or they could report UK - Unknown. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.

While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case **if Medicare PPS is a payer; mark 1-Early if the upcoming episode is the 1st or 2nd adjacent episode, mark 2-Later if the upcoming episode is the 3rd or > adjacent episode, mark UK if you don’t know and/or will not be making efforts to find out.**

M0246

Question 6: Can ICD-9 codes that are case mix codes be placed in M0246 on any OASIS which is a Non-PPS Payer? (Example: Medicaid HMO)

Answer 6: M0246 is an optional item and an agency is not required to complete it. When an agency chooses to complete M0246 in order to facilitate accurate payment, the general OASIS data collection instruction states “If a provider reports a V code in M0230/240 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0246.” The intention is that the case mix diagnoses that were replaced by V-Codes in M0230 and/or M0240 should be reported in M0246 to facilitate payment for any patient for whom the OASIS 1.6 data set is being used to determine an HHRG/HIPPS. M0246 is optional, and may be completed for any assessment which will be used to generate an HHRG/HIPPS code for payment, including payers other than Medicare PPS.

M0246 Rationale for repeating case mix diagnosis

Question 7: It is challenging for our agency to ensure that all assessing clinicians know the list of case mix diagnoses, and we want to insure they are coding based on appropriate guidelines and not focused on coding to increase reimbursement. As such, our policy is that whenever a V code is listed in M0230 or M0240, the assessing clinician will list in M0246, on the same line, the applicable numeric code reflecting the underlying condition related to the V code. In some cases, the numeric codes listed are case mix diagnoses and criteria are met for payment to be favorably increased. In other cases, the numeric codes listed in M0246 do not increase payment, and in fact may not even be from the case mix diagnoses list. Is this an acceptable practice?

Answer 7: If a numeric code is listed in M0246, it will only contribute to payment under PPS if it meets required conditions (e.g., is a case mix diagnosis, is listed in the proper sequence, replaces an eligible V code). A numeric code listed in M0246 might not affect payment because it is not a case mix diagnosis, or because it is a case mix diagnosis but does not meet all the conditions required to affect payment-- e.g., if the assessment does not include other responses (such as ADL dependence) that are needed for the diagnosis to earn points; or the code listed does not replace an eligible V code. If required conditions are not met, the code is ignored by the payment grouper. Listing an unnecessary code in M0246 is not a noncompliant or unacceptable practice; just unnecessary, as far as payment is concerned. However, in addition to potential payment impact, codes in M0246 also have a potential risk adjustment impact. The guidance from Chapter 8 for completing M0246 states "If a V code reported in any row in column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis in the same row in Column 3". However, a code reported in M0246 will be appropriately available and considered for risk adjustment even if it does not impact payment.

Question 8: I understand from the CMS OASIS OCCB 01/07 Q&A #17 that a case mix diagnosis may be listed at multiple levels in M0246. What is the rationale for repeating a case mix diagnosis more than once? Is there a payment implication? Is there a risk adjustment implication?

Answer 8: In some, less complex coding scenarios, the repeating of the same case mix diagnosis in M0246 (or listing a case mix diagnosis that is also reported in M0230 or M0240) may not have a payment impact. In more complex coding situations, repeating the code may have a payment impact, although the complexity of the scoring process may not make this readily apparent. For instance, when a V code replaces a condition that must be reported using mandatory multiple coding, and both the etiology and manifestation codes are case mix diagnoses from different Diagnostic Groups, PPS payment model criteria will determine which of the two codes will bring the most points, and it will contribute to payment, and the other will not. This means that the case mix diagnosis not used may be eligible to contribute toward payment if listed (repeated) at another level. It may not be readily apparent to the assessing clinician which of the case mix codes pair (the etiology or the manifestation code) was not selected for payment impact, and if that non-scoring case mix code meets conditions to be repeated at another level, and is not repeated, it will not be available for potential reimbursement increase.

Because of the complexity of the various opportunities to demonstrate increased patient acuity and favorably impact reimbursement through diagnosis reporting, it may be in the agency's best interest to enter case mix diagnoses that are replaced by V codes whenever this occurs, even if the listed code is duplicated, to minimize the chance of missing opportunities to gain eligible points toward payment.

Eligible diagnosis codes from M0246 are considered for risk adjustment calculation, but are only

considered once. Therefore duplicating or repeating a case mix diagnosis will not impact risk adjustment.

M0470, M0474, M0476 Stasis Ulcer items in OASIS 1.6

Question 9: There is some confusion regarding the stasis ulcer questions at the follow-up time points, specifically surrounding M0470 and M0474; if the patient does not have a stasis ulcer, are we required to answer M0470 and M0474, or should we skip these items? Even though not required, could we include M0468 on our follow-up assessments to facilitate a more familiar skip pattern at these time points?

Answer 9: At the SOC, ROC and D/C assessments, M0470, M0474 and M0476 would be skipped if the absence of a stasis ulcer was noted on M0468 (Response "0-no"). M0468, Stasis Ulcer Presence, is not included in the OASIS 1.6 Follow-up time points (RFA 4, Recertification and RFA 5, the Other Follow-up). Therefore, there is no skip pattern available at the follow-up or recert time points. If there are no stasis ulcers, the clinician may answer M0470 "0-Zero" and M0474 "0-No"; or skip these two items. Since M0468 is an inactive field for RFA 04 and 05, if it is submitted, any value in this field is ignored and is not used for editing the submission nor is it stored in the database. Therefore, agencies can continue to submit M0468 (as well as M0445 and M0482 – the "gateway" items for pressure ulcers and surgical wounds) on RFA 04 and 05 if they like without errors. Please refer to the official data sets to identify the specific items required by time point.

M0482

Question 10: Are arthrocentesis sites considered surgical wounds? Thorocentesis sites?

Answer 10: When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate fluid and then removed, (no drain left in place), it should not be reported as a surgical wound.

If a physician performs a surgical procedure via arthroscopy, the arthrocentesis site would be considered a surgical wound until it heals and becomes a scar/lesion.

M0520 Nephrostomy

Question 11: How should we answer M0520 for a patient with a nephrostomy tube? The nephrostomy tube is not discussed directly in the RESPONSE-SPECIFIC INSTRUCTIONS area or Q&As. It does state that if the patient has an ostomy for urinary drainage (e.g. ileal conduit/urostomy, ureterostomy) mark response "0", no incontinence or catheter. Many are interpreting this to mean anything ending in "ostomy" is not a catheter. The problem with this logic is that it would exclude a suprapubic catheter because it is actually a cystostomy.

Can we interpret M0520 to mean if the urinary diversion is pouched with an ostomy appliance it is not a catheter but if it is accessed with a tube or catheter (external or otherwise) then the patient has a catheter? What about the patients with continent urinary diversions? They have a stoma but are accessing with intermittent catheterizations. Would they be reported as having a catheter on M0520?

Answer 11: When a patient has urinary diversion, with or without a stoma that is pouched for drainage the appropriate M0520 response would be "0-No incontinence or catheter". The appropriate response for a patient with urinary diversion, with or without a stoma, that has a catheter or "tube" for urinary drainage would be "2 -Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)." A patient that requires intermittent catheterization would be represented by Response 2, even if they have continent urinary diversions.

M0800

Question 12: I need more clarification regarding what is included and not included in M0800 and what are we assessing. We have a patient that is receiving injections at her physician's office, mainly for financial reasons, do we include those injections.

Answer 12: When a patient is receiving an injectable medication in the physician's office or other setting outside the home, it is not included in the assessment of M0800, Management of Injectable Medications.

M0800, Management of Injectable Medications, reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health plan of care. M0800 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.

M0800 includes all injectable medications the patient has received or will receive in the home during the home health plan of care for the "current" status, and 14 days prior to the SOC/ROC date for the "prior" status. Note that if an injectable medication is given by a nurse, the clinician will need to determine if the administration by the nurse was for convenience, or if administration by the nurse was ordered by the physician which represents a medical restriction inferring that the patient is unsafe/unable to self-inject. If that was the case, the appropriate response for M0800 would be 2-Unable to take injectable medications unless administered by someone else. (Note this is a change from earlier guidance provided in the OASIS Web-Based Training.)

M0800 would also include one time injections that were ordered to occur in the home as long as the administration occurred during the period of time covered by the plan of care. If the patient administered the medication, the clinician would report the patient's ability to complete the included tasks on the day of the assessment. If the injection was ordered but not to be administered on the clinician's day of assessment, the clinician will use the assessment of the patient's cognitive and physical ability and make an inference regarding what the patient would be able to do.

Question 13: If a patient has a "Baclofen pump infusion" does it even fall into M0800? It is being administered "intrathecally". The patient and the nurses are not doing anything with it. Everything is being done by the doctor's office. I did find the question from the web-based training that states that insulin sub-q pump is considered here as well as pain meds via epidural infusion so does this fall into that category?

Answer 13: Only medication that is injected is to be considered for M0800. Injectable medications include medications that either the patient or medical staff inject via needle and syringe subcutaneously or intramuscularly while in the home. Infusions are excluded from consideration, e.g. medications infusing via an implanted pump or external infusion device. This guidance represents a change from prior guidance found in the OASIS Web-Based Training.

Question 14: We would like a clarification related to patients who draw up medication and refill an implanted pump (such as an epidural) themselves at home. For M0250 the response would be #1 as per the OASIS Manual. For M0800 would this response be 0. If a company comes in to the home and fills the pump at home, how would we respond to M0250 and M0800? If the patient goes to a physician's office to have it filled, how would these questions be answered?

Answer 14: If the epidural infusion is occurring in the home, it is included in M0250, regardless of who is managing the infusion.

When a patient is receiving an epidural infusion, the infusion is not considered for M0800 regardless of whether it is filled and/or infusing in the home or the office. M0800 Injectable Medications includes medications that either the patient or medical staff directly inject via needle and syringe subcutaneously or intramuscularly. Medications where the route of administration is infusion (e.g., sub-q, epidural, or IV) are not considered injectable medications, even if the medication is injected into the pump, chamber, or other external or implanted access/infusion device via a needle/syringe by the patient.

M0826

Question 15: I am uncertain how to answer M0826 in the following situations, please clarify:

a. At ROC?

b. When patient has multiple payers and some therapy services are covered under the Medicare home health benefit and other therapy services are not (e.g. patient in a long term home health care program (LTHHCP) or one who pays privately for therapy beyond what is considered reasonable and necessary)?

c. When I add therapy services mid-episode?

Answer 15:

a. At ROC M0826 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4), data from M0826 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0826 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not needed for payment, response NA - Not Applicable: No case mix group defined by this assessment could be reported on M0826. Alternatively, providers may choose to report the total of therapy visits that have been provided during the episode to date, added to the number of therapy visits planned to be provided during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.

While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60 day episode should be reported.

b. Therapy services that are not covered by the Medicare HH benefit: M0826 should reflect the total number of reasonable and necessary therapy visits (e.g. therapy visits that meet the Medicare home health coverage criteria) that the agency plans to provide during the payment episode. If the agency intends on providing therapy visits that do not meet the Medicare home health coverage criteria (e.g. more frequent than necessary, custodial or repetitive in nature), including those which the agency intends to bill to another (non Medicare PPS) payer, only those visits that meet the Medicare home health benefit coverage should be reported in M0826.

c. Therapy services added mid-episode: When therapy services are ordered within the episode, the RFA 5 (other follow up) assessment may be required, depending on your agency's established policy and practice. The number of visits reported in M0826 on the RFA 5 assessment will in no way impact the episode payment under Medicare PPS. Upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the actual number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M0826. The agency does not have to go back and make any changes or corrections to M0826 at the SOC or other time points.